25 MAY 2016 Waterfront Meeting

	Speaker	Topic	Time
MRD-SD	LT Hightower	Curriculum Review/Pretest	15
MRD-SD	LT Chace	Patient Case Review	10
NMCSD GI	LCDR Stickle	GI Bleeding	45
NMCSD MH	LT Gaines	Mental Health Access to Care	30
NMCSD Infect. Dis.	Dr. Stone-Garza	HIV Post Survey	10
NMCSD Audiology	Dr. Harris	Occupational Audiology	10
MRD-SD	LT Hightower	Post Test	5
		Total	125

Case Presentation:
A Delayed Cancer Diagnosis

LT Hillary A. Chace, D.O.
Performance, Assessment, and Improvement Coordinator
Medical Readiness Division San Diego
Naval Surface Forces Pacific

Purpose

- To provide a safe venue for providers to identify areas of improvement, and promote professionalism, ethical integrity and transparency in assessing and improving patient care.

- To foster a climate of openness and discussion about medical errors.

All cases are confidential and names have been removed. For Educational purposes only.

Case

- 38yo active duty Sailor presented to ship's Medical Officer complaining of 2 day history of constipation, passing hard infrequent stools and blood on the toilet paper after wiping.
  - Received saline enema with subsequent bowel movement.
  - GMO documented to follow-up if bleeding continued.
  - No documentation of rectal examination.

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- 2 months later: Patient presented to sick call with dry cough, fatigue and sore throat with no mention of GI complaints from prior visit.

- 8 months later: Patient saw the IDC in sick call complaining of blood in stool for 6 months, painful bowel movements and rectal pruritus.
  - IDC ordered stool culture, ova & parasite lab.
  - Rectal exam, inspection only, was performed and documented as “no obvious protrusions and fissures noted, no obvious source of bleeding.”
    - Digital Rectal Exam not performed.
  - Assessment and plan included “after lab results, place GI consult.”
    - GI consult was NOT placed.

- 1 month later: Patient transferred to an IDC platform.

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- 4 months later: Reported to sick call with same symptoms.
  - Per patient, he was given fiber and stool softeners.
  - No documentation in chart or AHLTA and, when asked, IDC reported verbal orders were given to return if symptoms didn't improve.

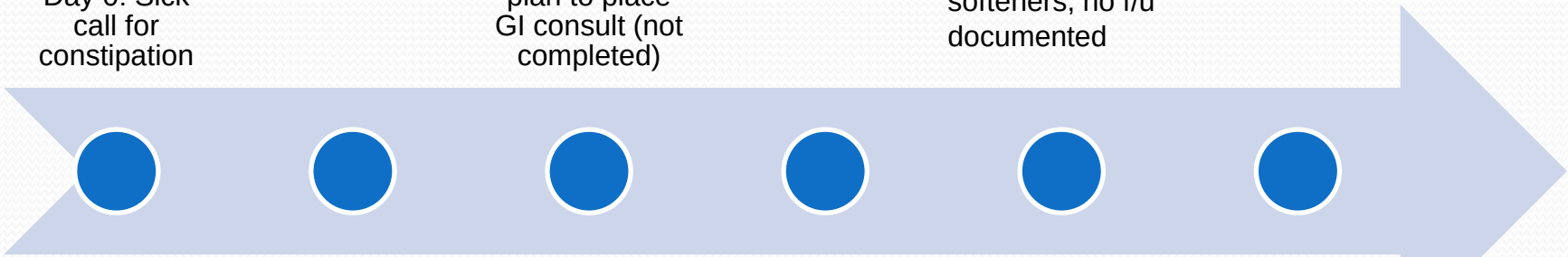
- Two weeks later: Pt returned to sick call complaining of painless rectal bleeding, feeling of constant pressure in his rectum, and intermittent urinary complaints.
  - Rectal exam, including Digital Rectal Exam, performed and documented as "enlarged nodule." IDC was unclear if this was isolated to prostate and diagnosed with prostatitis.
  - IDC reviewed this with physician supervisor and a joint plan was made to order diagnostic and screening labs (prostate specific antigen, fecal occult blood, complete blood count and urinalysis) and referral to NMCSD GI was placed.

- 3 weeks later: Patient saw GI and had a colonoscopy which showed a large, fungating rectal mass.
  - Biopsy confirmed adenocarcinoma.

- 3 weeks later: Sent to General Surgery with initial clinical staging T3-T4N0M0.

- 2 days later: Sent to Radiation Oncology and Hematology Oncology where he was staged as T3N1M0 and underwent Xeloda chemotherapy and radiation with plans for surgical excision.

Timeline



Day 0: Sick call for constipation

2M: Sick call for URI sx

8M: Sick call for blood in stool x 6 months, 1st rectal exam, plan to place GI consult (not completed)

9M: Pt transferred to IDC platform

13M: Sick call for same symptoms, given fiber/stool softeners, no f/u documented

13M 2W: Sick call for painless rectal bleeding, rectal pressure and intermittent urinary complaints, dx with prostatitis, labs drawn, GI consult officially placed

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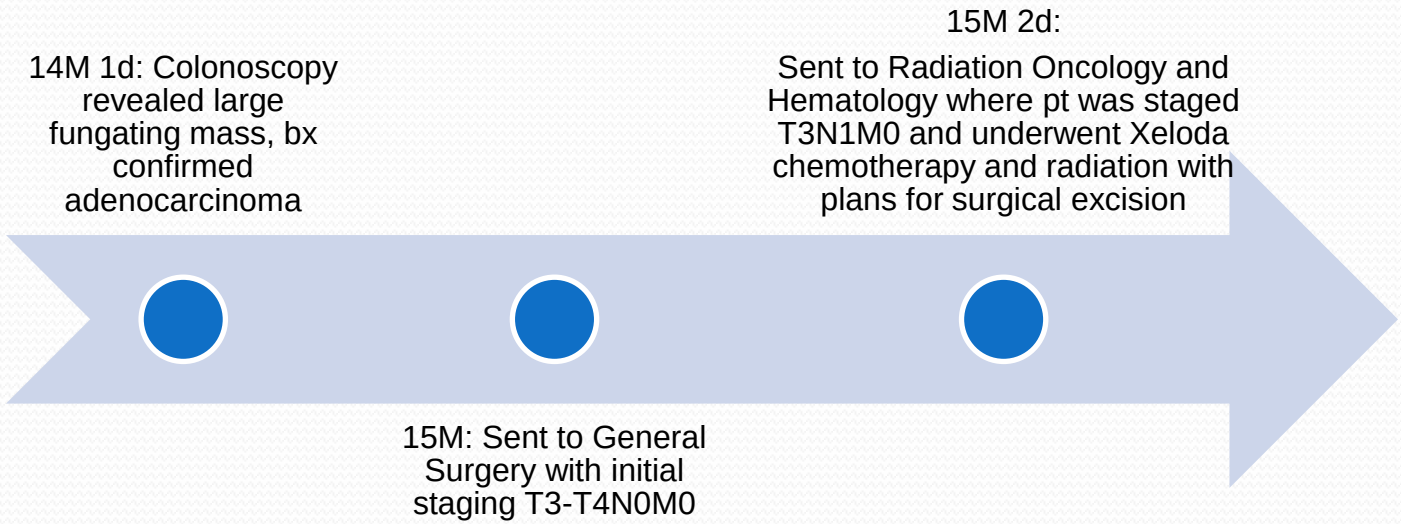
M: Month
W: Week



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Categories for Occurrence Reports

(1) Category I. Predictable event within the standard of care.

(2) Category II. Unpredictable event within the standard of care. Category II does not represent an escalation of seriousness over Category I; they are both within the accepted standards of care.

(3) Category III. Marginal deviation from the standards of care: "Marginal" events in this category reflect care that is minimally outside of the contemporary standards of the specialty or the expected standards of the departmental staff.

(4) Category IV. Significant deviation from the standard of care. Events in this category usually speak for them themselves as significant departures from the expected standards.

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Overall Recommended Category

- Category IV
  - No evidence that rectal exams were performed upon initial and subsequent presentation for rectal bleeding.
  - No evidence that a GI referral was ordered despite being mentioned in A/P sections of the SOAP note.
  - No documentation regarding attempts to contact patient for follow-up labs or GI referral.

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Standard of Care

- Digital rectal examination (DRE) is standard of care for patients presenting with rectal bleeding, especially on repeat visits.
- Referral to Gastroenterology or General Surgery specialty clinic for determination of etiology of chronic rectal bleeding should be given.

Quality Assurance Committee Recommendations

- Review topics at Waterfront Meeting for both physicians and IDCs:
  - Evaluation/Management of rectal bleeding, to include when to refer to specialty clinics.
  - Differential diagnosis of rectal bleeding.
  - DREs (indications/proper techniques).
  - Principle of having a high index of suspicion.
  - Principle of close follow-up.
  - Proper documentation of patient follow-up instructions.
  - Emphasizing the understanding that a young patient can get cancer.
  - Avoidance of "p-way medicine."

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Specific Details of This Case

- Poor follow-up.
- Not performing or documenting DREs.
- Not asking about previous rectal bleeding symptoms during subsequent visits to Medical.
  - Principle of documenting pertinent negative findings after review of past medical encounters.

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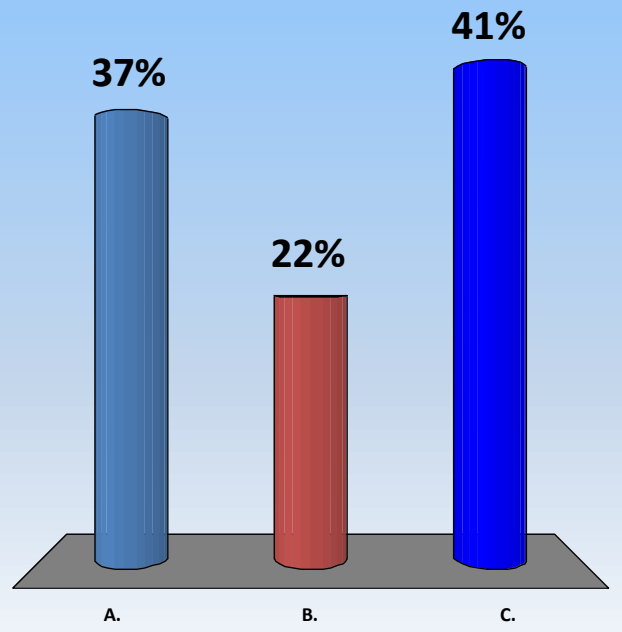
You are preparing to deploy in 2 months. As part of workup, you are reviewing medical readiness records. You note that one of your sailors has a diagnosis of ulcerative colitis and was last seen by GI 9 months ago. Their current medications include Lialda (mesalamine) 2.4 gm daily. How do you next proceed?

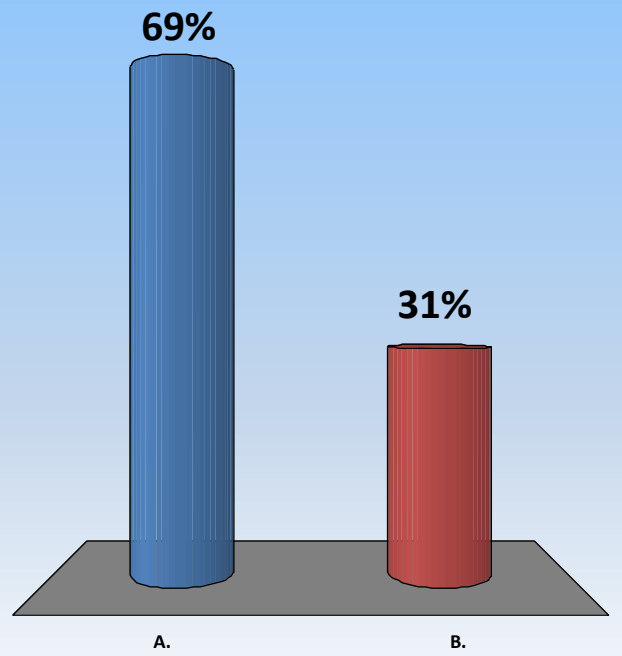
A. Refer back to GI for LIMDU or PEB, but do not plan on taking sailor on deployment
B. Ensure patient has >6 month supply of medications for deployment and clear for duty
C. Evaluate patient personally in sick call



You are reviewing records for upcoming ship gains. One of the sailors is scheduled to transfer from Yuma. PCM notes state the sailor is being followed in town for ulcerative colitis. It appears that they are taking Lialda (mesalamine) 4.8gm daily as well as Imuran (azathioprine) 50mg daily. It appears from the PCM notes that the patient is in remission and asymptomatic.

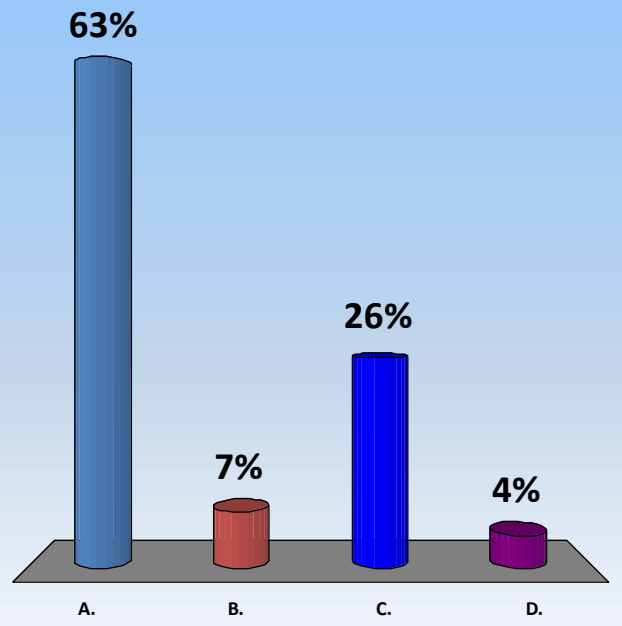
A. Accept the sailor and refer to GI

B. Decline as medically unfit



A 40 year old MMC presents to sick call complaining of intermittent painless hematochezia, mostly noted on the toilet paper. You perform a rectal exam and do not note any external hemorrhoids and do not palpate any masses nor note any gross blood on the glove.
How do you next proceed?

A. Use guaic card with residual stool on glove to check for bleeding
B. Start patient on fiber and docusate
C. Refer to GI
D. Perform anoscopy



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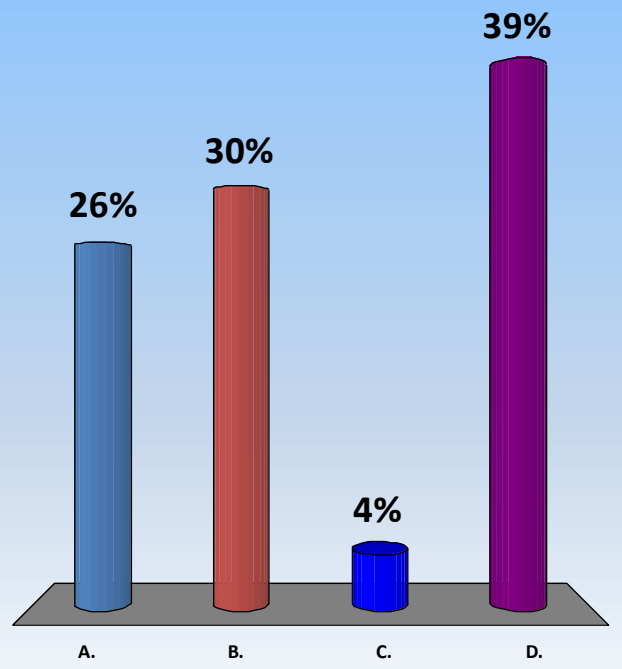
A. Given 150mg Zantac (ranitidine)
B. Give 20mg PO Prilosec (omeprazole)
C. Immediately transfuse 2 units O negative PRBCs
D. Place a NG tube for gastric lavage



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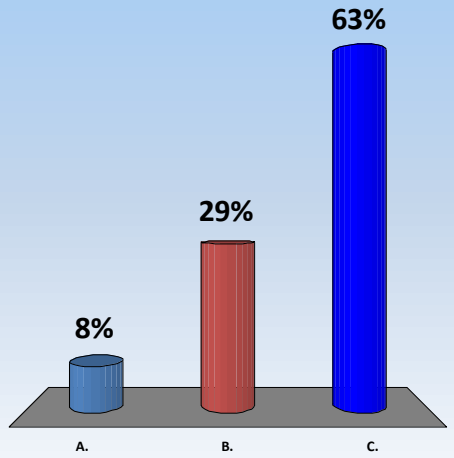
A. Start prednisone 60mg burst for likely ulcerative colitis
B. 1L NS and serial abdominal exams
C. Inform the XO that you have a medevac patient



Rectal Bleeding for the Operational Provider

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I have no relevant financial relationship with any commercial interests to disclose.

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Topics

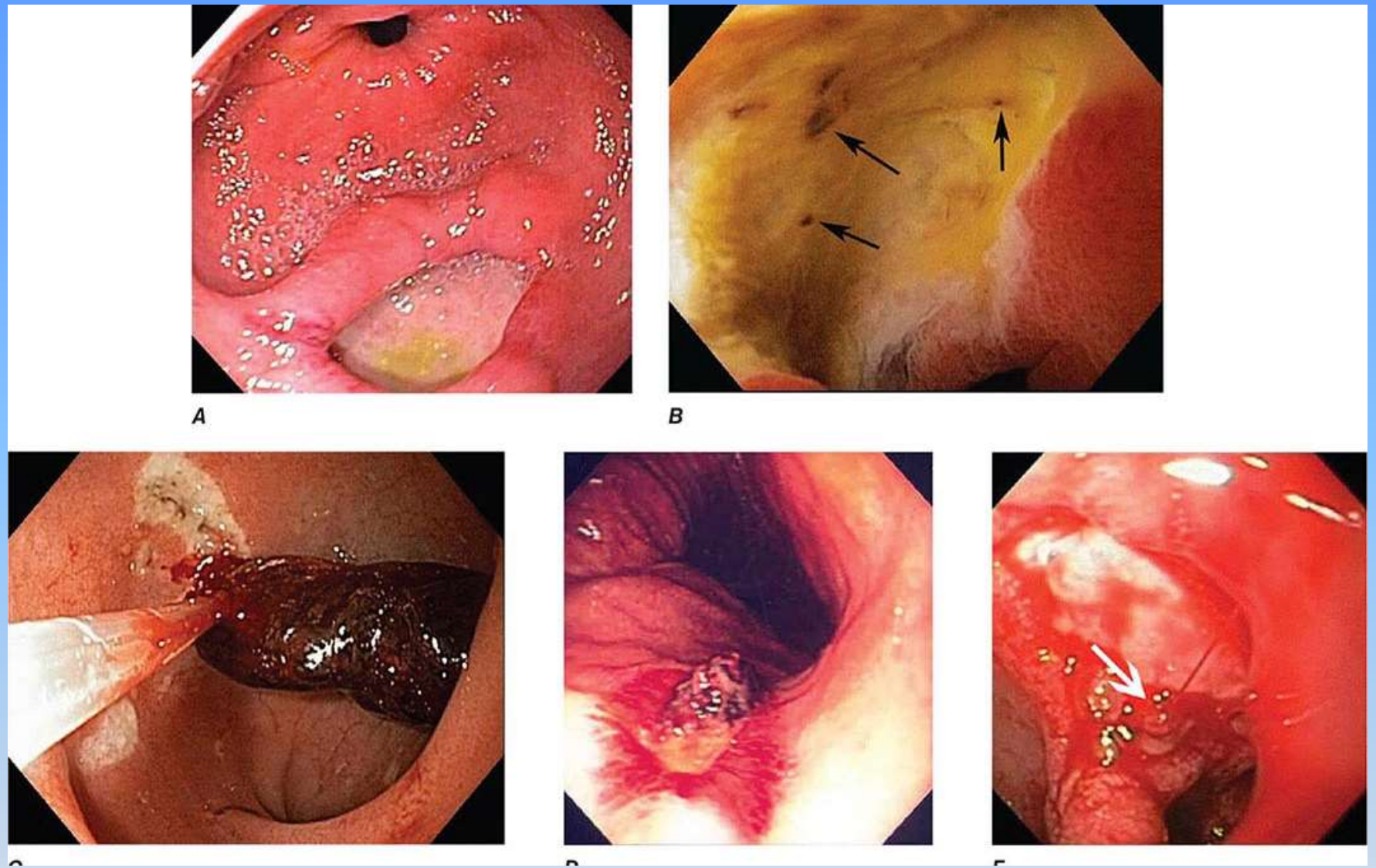
- Upper GI bleeds and management
- Lower GI bleeds (hematochezia)
  - Infectious colitis
  - Ischemic colitis
  - Inflammatory bowel disease
  - Diverticular disease
  - Rectal disorders
  - Malignancy

Broad Concepts

- Determine upper vs lower
  - Upper more likely to be life threatening
  - Melena, elevated BUN, hematemesis, CBC to include MCV
  - Right sided lower GI bleed can present with melena
  - Orthostatic?
- Acute vs chronic (UGI usually acute/subacute)
- Abdominal pain or painless hematochezia?
- Med reconciliation to include supplements/OTCs
- DRE ALWAYS indicated

Upper GI bleed

- DDx
  - Peptic ulcer disease (most common)
  - Mallory Weiss tear (episode of emesis ending with hematemesis)
  - Variceal bleed
  - Dieulafoy lesion
  - Gastric/esophageal cancer
  - Other much more rare etiologies



Ulcer Staging, low risk and high risk

http://clinicalgate.com/tag/harrisons-principles-of-internal-medicine-19_e-vol-1-vol-2_nodrm/

Acute Management

- Fluids
- PPI
  - Drip in current guideline, 80mg bolus, 8mg/hr
  - Recent studies prove 40mg IV BID is non-inferior
  - If no IV PPI, give orally
  - PPI far superior to H2 blocker
- Transfuse if needed
- Usually medevac

Hematochezia

- History, history, history
- DDx
  - Infectious colitis
  - Ischemic colitis
  - Inflammatory bowel disease
  - Diverticular bleed
  - Malignancy
  - Rectal (fissures, hemorrhoids, rectal ulcers)

Infectious Hemorrhagic Colitis

- Pt may or may not be ill, recommend supportive care without antimotility agents (Imodium/Lomotil)
- EHEC (E coli O158:H7)
  - Supportive care, abx may increase risk of HUS
- Campylobacter – associated with development of Guillain-Barre and reactive arthritis
- Salmonella
- Shigella
- Entamoeba histolytica

Ischemic Colitis

- Have period of ischemia to gut (maybe after vigorous working out) resulting in crampy abdominal pain. Subsequently develop bloody stools when colon re-perfused
  - Pain usually resolved prior to hematochezia
  - Implicating meds- opioids, vasoconstictors (Sudafed), constipating meds, h/o IBS-C
  - Ongoing pain raises concern of ongoing ischemia/alternative diagnosis
  - Treatment supportive (fluids, serial exams)
  - May potentially stay on ship for mild cases based on your comfort and clinical course

Diverticular Bleed

- Painless hematochezia
- May result in significant blood loss
- Diagnosis via endoscopy, prior CT or other evidence of diverticulosis helpful
- Supportive care while arranging medevac
- 70% stop spontaneously, medevac if bleeding recurs. Anecdotally, majority will stop with 4L bowel prep

Inflammatory Bowel Disease

- Crohn's and Ulcerative colitis
- Tend to present with intermittent episodes of hematochezia or other symptoms (generally a subacute presentation in hind sight)
- May have extracolonic manifestations with uveitis, anklyosing spondylitis, erythema nodosum
- If have not been diagnosed previously, need to medevac for diagnosis and management

So no one with IBD can be on a ship?

- Well….. Not exactly
- Cannot be on biologic therapy (Humira, Remicade, Entyvio) or immunomodulator (methotrexate, azathioprine, mercaptopurine)
- Can be on 5ASA therapy (mesalamine or sulfasalazine)
  - Lialda (either 2.4, 3.6, or 4.8g daily)
  - Canasa suppository 1000mg QAM or BID
  - Rowasa 4g QHS or BID

So who is that?

- Most common- mild ulcerative colitis clinically in remission on mesalamine monotherapy
  - Generally ulcerative proctitis or left sided disease
  - More rarely pancolitis
- Rarely mild right sided Crohn's colitis in remission on mesalamine (rare phenotype)

IBD Sick Call Management Underway

- If symptoms mild, not sick, ensure compliance with therapy. Escalate combo mesalamine therapies to max doses
- Rule out C. Diff at first opportunity
- If not improving, call us or medevac
- Low threshold to medevac

IBD Steroid Guidance

- Continue to be symptomatic after maximizing 5ASA therapies
- Ulcerative proctitis – trial of steroid suppository before systemic steroids
- Steroid ‘burst’ does not apply to IBD
  - An acceptable regimen: Prednisone 40mg for 2-4 weeks with a rapid taper
- If clinically deteriorate, start abx (Cipro/Flagyl) and medevac at earliest opportunity
- We are always available to discuss concerns
  - Duty Phone Number 619-886-1238

Anorectal Disorders

- DRE absolutely indicated in all cases of hematochezia
- Anal fissures are exquisitely painful
- External bleeding hemorrhoids may be painful or pruritic
- External thrombosed hemorrhoids painful
- Internal hemorrhoids frequently palpable but are non-painful
- Confirm with anoscopy

Digital Rectal Exam

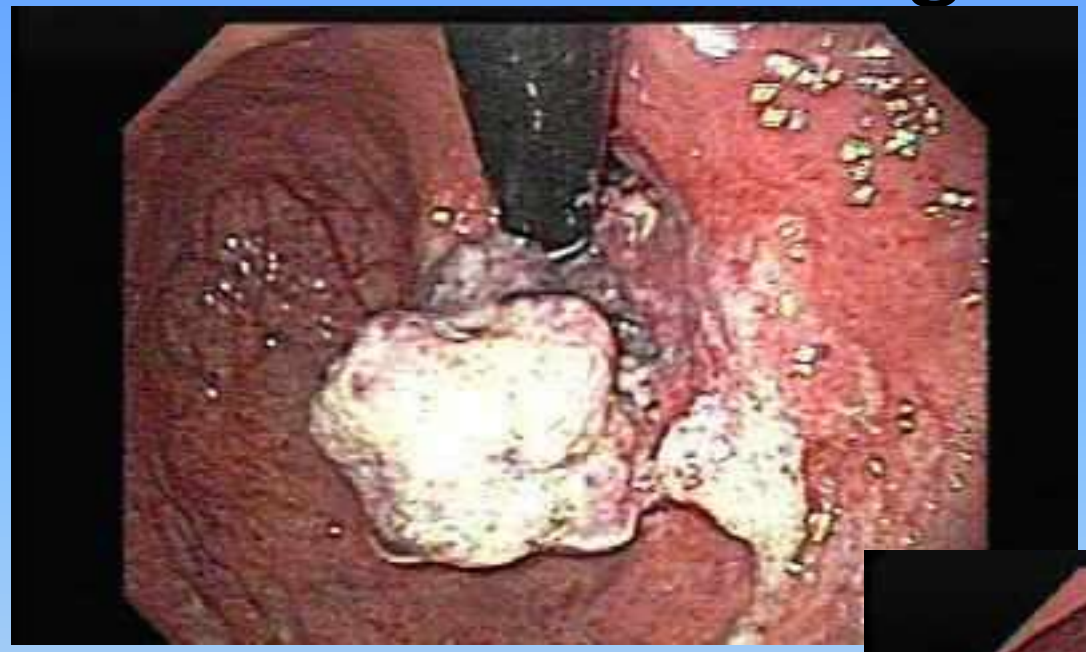
- ABSOLUTELY should be performed in any patient complaining of bleeding, and do not defer to referring physician
- Put the guaiac card away (preferably in trash can)
- Start with careful external visual exam, especially if complaining of pain with defecation, carefully look for fissure/tear
- Generous lube, insert finger to furthest extent possible
- Have pt bear down to shorten rectal canal and sweep finger feeling for mass
- Non-prolapsed internal hemorrhoids (grade 1,2) will feel like smooth, palpable masses at anal verge

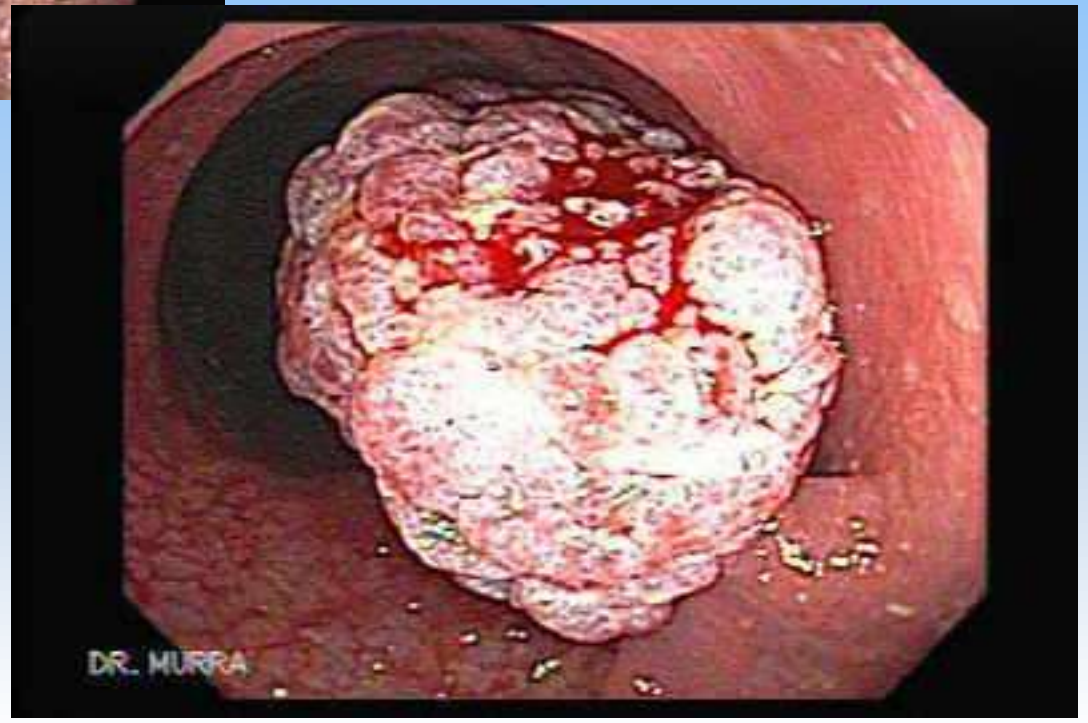
Hemorrhoids

Hemorrhoid Management

- Bowel regimen to soften stool. Minimum of docusate, preferably Miralax
- Increase fluids and fiber
- Proctofoam (steroid and local anesthetic)
- Avoid excessive time stooling
- Sitz baths twice daily
- If still symptomatic consider addition of Anusol
- If still symptomatic, elective General Surgery referral

Malignancy





Malignancy

- Distal cancers tend to present with intermittent, painless hematochezia, perhaps accompanied with change in stool caliber or obstructive symptoms
- Digital rectal exam with palpation of rectal vault mandatory in all cases of hematochezia
- Strongly discourage use of FOBT, especially with DRE
- If palpate mass, recommend medevac for further eval

Bottom Line

- Not all hematochezia requires medevac
- Not all hematochezia requires referral
- Hemodynamically significant bleeding warrants medevac, starting PPI prior to transfer can potentially make huge clinical impact
- Infectious colitis – generally supportive care and serial follow-up
- Ischemic colitis – mild cases likely can remain on ship. SIRS symptoms or ongoing abdominal pain good reasons to medevac

Bottom Line

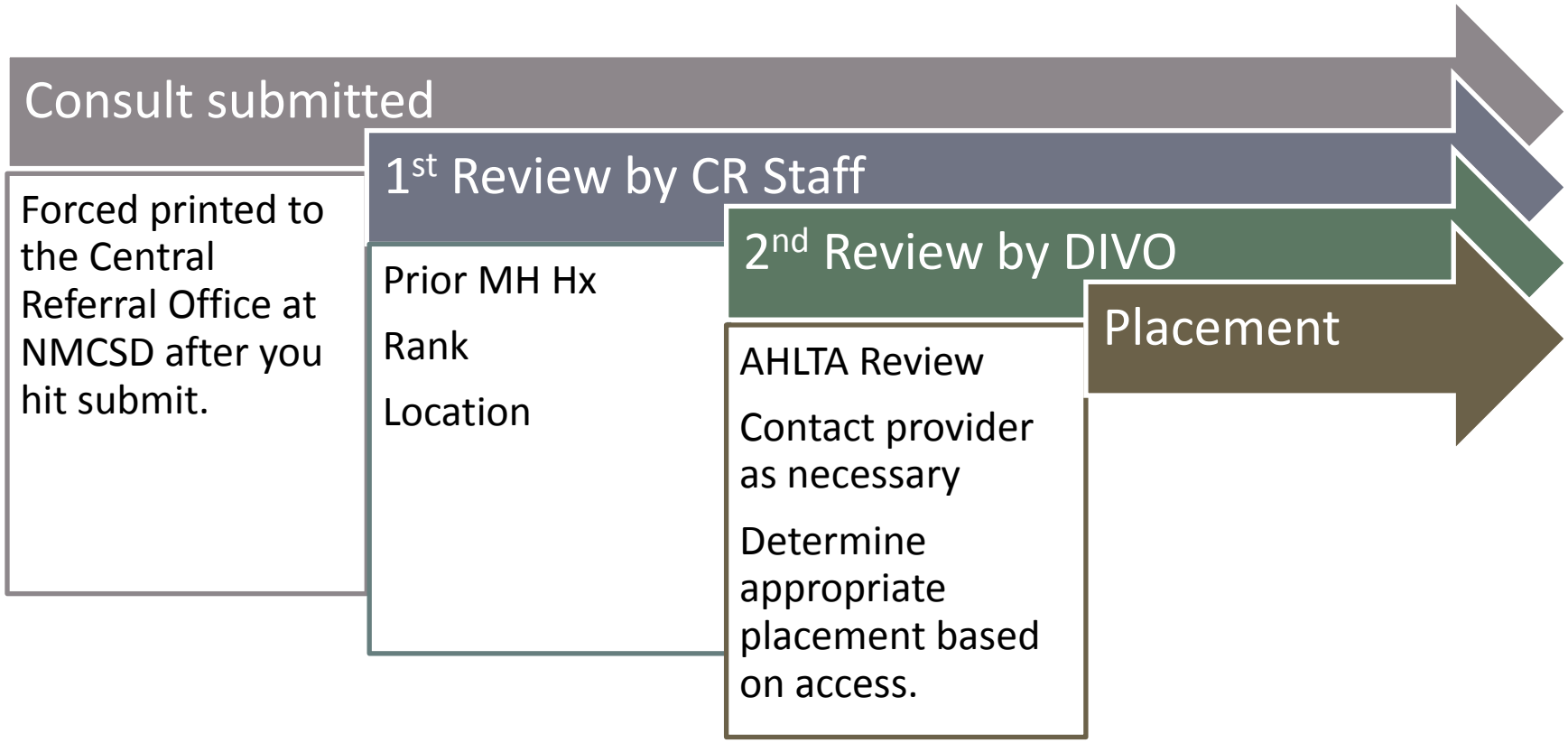
- Mild flares of previously diagnosed IBD potentially may be treated on ship, feel free to contact us for advice
- Ongoing abdominal pain with intermittent hematochezia -> consider medevac if concern for IBD
- Ongoing intermittent or progressive painless hematochezia with stool changes (despite bowel regimen) -> refer
- Mass -> medevac

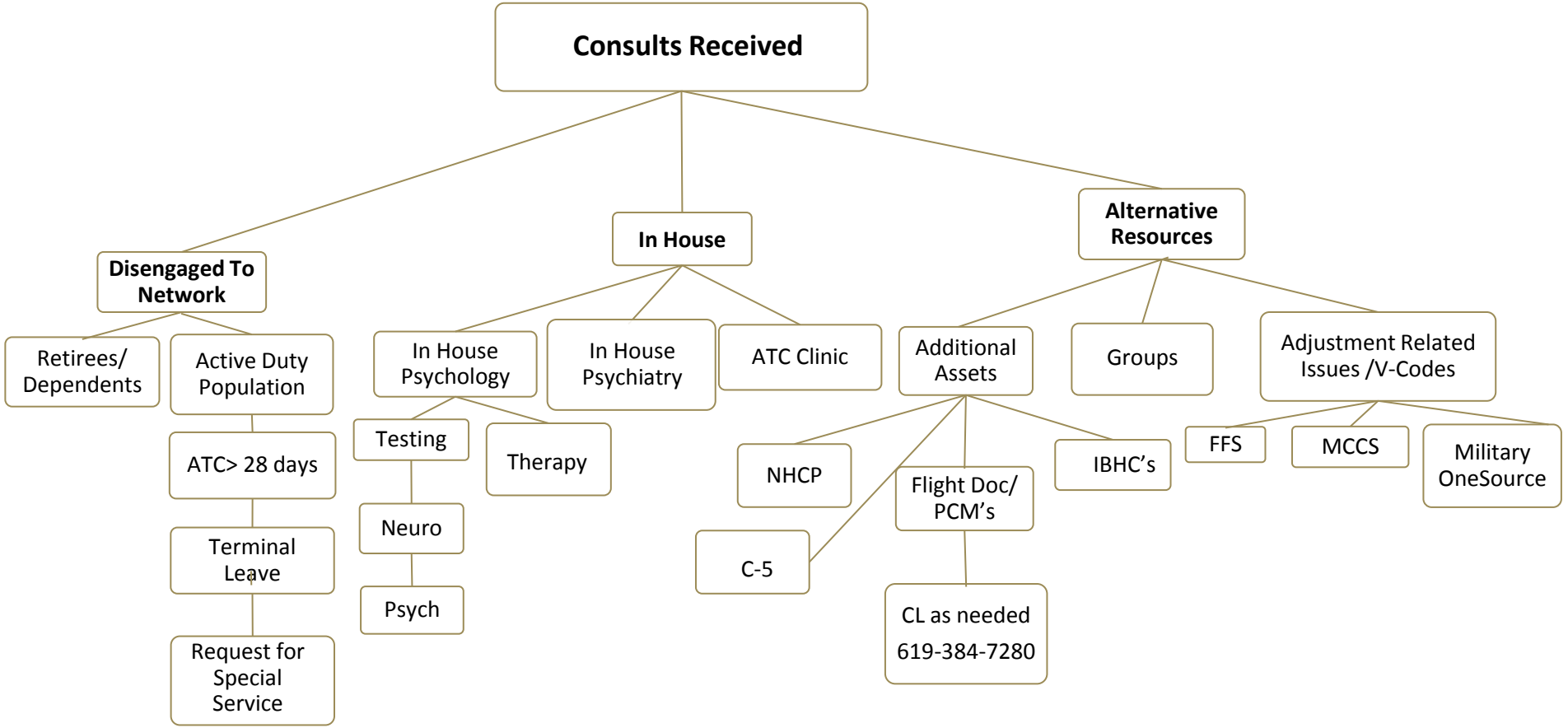
NMCSD, DMH
Central Referral Division

Stephanie J. Gaines, PsyD
LT USN MSC
Work: 619-532-5883
Central Referral Office: 619-532-6354

DMH “Life of a Consult”

**DMH Receives an average of 700 consults each month*




Consults Received
Disengaged To Network
In House
Alternative Resources
Retirees/ Dependents
Active Duty Population
ATC> 28 days
Terminal Leave
Request for Special Service
In House Psychology
In House Psychiatry
ATC Clinic
Testing
Therapy
Neuro
Psych
Additional Assets
Groups
Adjustment Related Issues /V-Codes
NHCP
Flight Doc/ PCM's
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CL as needed
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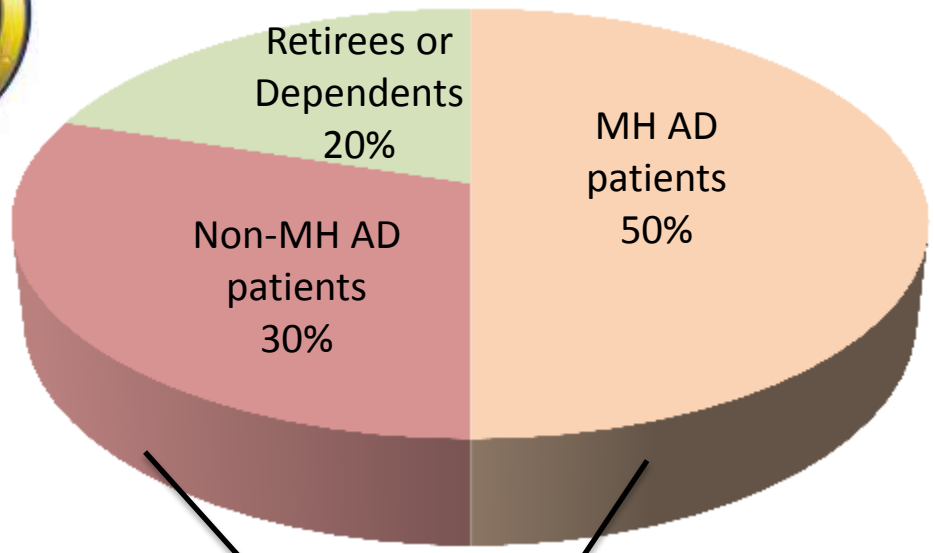
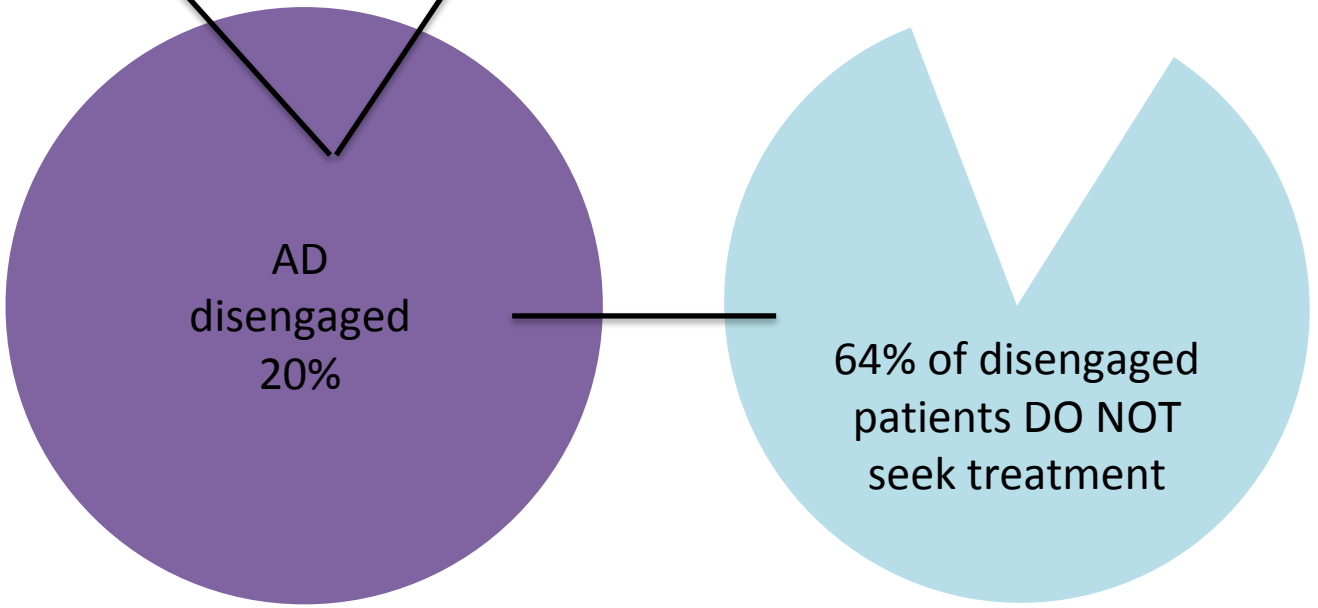
Military OneSource



700
MONTHLY CONSULTS RECEIVED



Disengagement Process

- During the consult review process, each consult is assessed by the Central Referral DIVO and determined if the patient is appropriate/inappropriate for disengagement to the network (United Healthcare - UH) and for what type of service (psychiatry or psychology)
  - What is considered?
    - Access to Care greater than 28 days
    - Duty Status (LIMDU/PEB/ADSEP)
    - Do they have an in-house provider to assess duty status
    - Community (Flight/SUB etc.)
    - Transportation
    - Diagnosis
    - Willingness to be disengaged
- Once chosen for disengagement, the consult is routed to Utilization Management and “Referred to Subspecialty” indicating psychology or psychiatry
  - 9 visits (psychology and psychiatry)
  - 14 visits for PTSD.

Disengagement Process

- Patient is contacted and explained the disengagement process.
  - Patient is told to contact the UH Centralized Scheduling number @877-988-9378 the next business day.
  - The patient is then given a specific provider name and number from UH that has been assigned to them.
    - **This provider is specifically chosen for them based on geographic region and agreement with UH
    - Not ALL providers that accept Tricare agree to see Active Duty.
    - If we disengage for psychology, they are not authorized to see psychiatry and will pay out of pocket.
- If more visits are needed.
  - The network provider must request additional sessions to Central Referral and approved by us. Each case is examined on a case-by-case basis.
  - The network provider and patient are contacted to assess if the patient needs to be recaptured or granted more visits.

Resources

- Chaplain
- Resiliency Counselors
- Internal Behavioral Health Consultants
- Military One Source
- Fleet & Family Support Centers
- MCCS
- Military Crisis Line 1-800-273-TALK
- SMO’s
- DMH

Elements of a MH Consult

- Priority: ROUTINE only
- Name, Rank, Duty Station
- Presenting symptoms
- History of MH treatment
  - Medication
  - Therapy (FFCS, MCCS, Military One Source Chaplain etc.)
- Specific Request: Medication, Therapy, Groups
  - 1 consult per service
- Fitness for Duty Concerns
- Special considerations
- Good contact number

You are preparing to deploy in 2 months. As part of workup, you are reviewing medical readiness records. You note that one of your sailors has a diagnosis of ulcerative colitis and was last seen by GI 9 months ago. Their current medications include Lialda (mesalamine) 2.4 gm daily. How do you next proceed?

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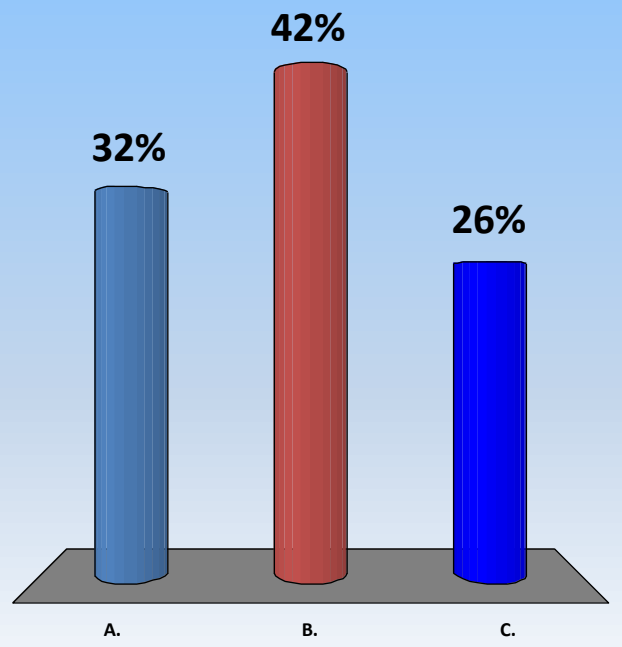

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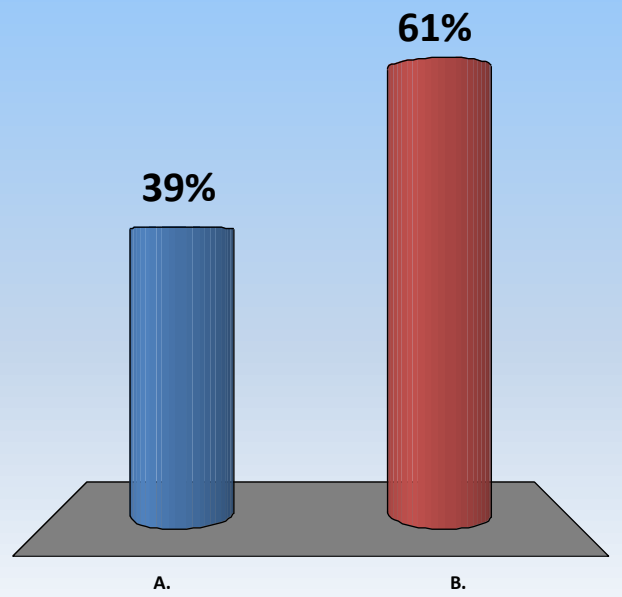
A. Accept the sailor and refer to GI

✓ B. Decline as medically unfit



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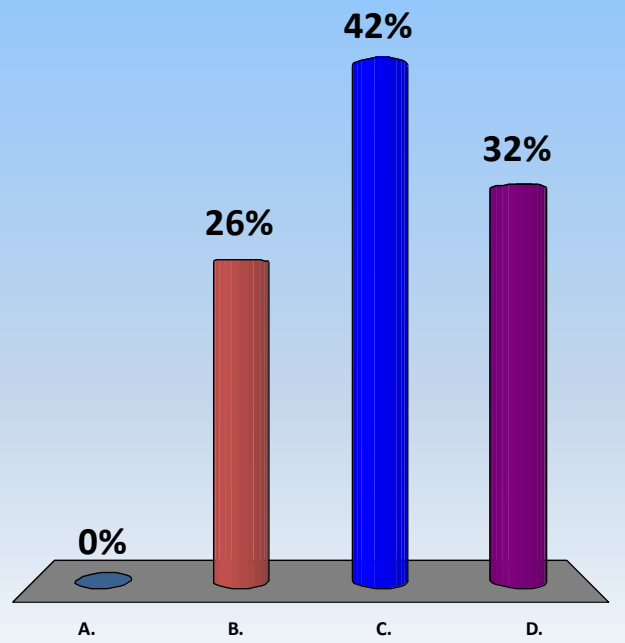

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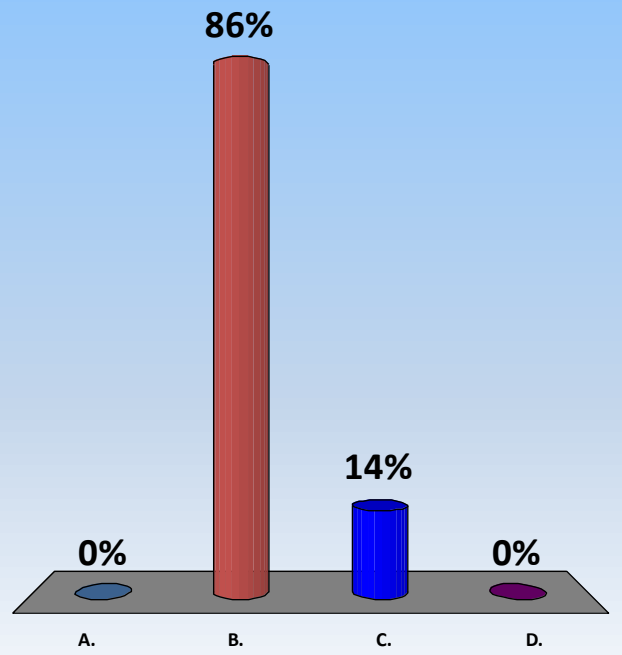

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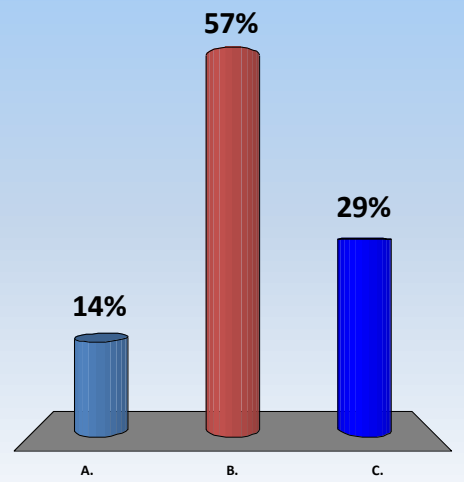
✓ B. 1L NS and serial abdominal exams

C. Inform the XO that you have a medevac patient



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Medical Readiness Division

MRD_SD_GMO@navy.mil

(619) 556-5191

Bldg 116

San Diego, CA 92136

Active Duty Clinic-Gen Surgery

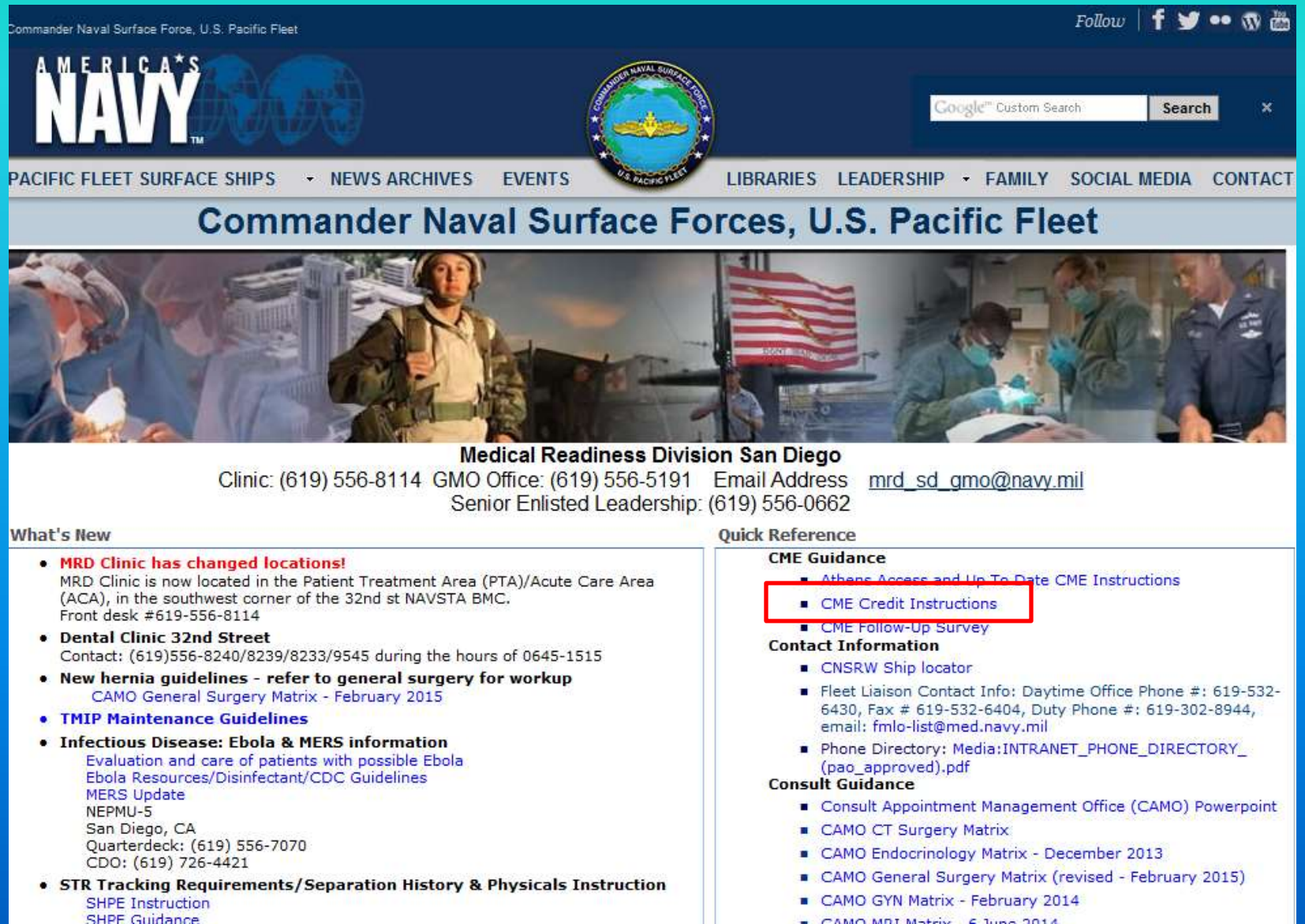
- Director, MRD CDR Hoang has volunteered to see common general surgery pathology on Fridays at Dept of Surgery, NMCSD to fast track fleet referrals, including:
  - Soft tissue (lipoma, epidermal inclusion cyst, pilonidal cyst);
  - Anal disease (hemorrhoid, anal/rectal abscess);
  - Screening colonoscopy
  - Symptomatic cholelithiasis
  - Hernia (ventral, incisional, inguinal, umbilical)

  - Gen surg matrix referral rules still apply.

- Conditions requiring long term follow up will not be included in active duty clinic, unless discussed with MRD Physician Supervisors.

- Include “forward to Dr. Hoang” in body of the referral.

CME – how to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Commander Naval Surface Forces, U.S. Pacific Fleet
Medical Readiness Division San Diego
Clinic: (619) 556-8114 GMO Office: (619) 556-5191 Email Address mrd_sd_gmo@navy.mil
Senior Enlisted Leadership: (619) 556-0662
What's New
MRD Clinic has changed locations!
MRD Clinic is now located in the Patient Treatment Area (PTA)/Acute Care Area (ACA), in the southwest corner of the 32nd st NAVSTA BMC.
Front desk #619-556-8114
Dental Clinic 32nd Street
Contact: (619)556-8240/8239/8233/9545 during the hours of 0645-1515
New hernia guidelines - refer to general surgery for workup
CAMO General Surgery Matrix - February 2015
TMIP Maintenance Guidelines
Infectious Disease: Ebola & MERS information
Evaluation and care of patients with possible Ebola
Ebola Resources/Disinfectant/CDC Guidelines
MERS Update
NEPMU-5
San Diego, CA
Quarterdeck: (619) 556-7070
CDO: (619) 726-4421
STR Tracking Requirements/Separation History & Physicals Instruction
SHPE Instruction
Quick Reference
CME Guidance
Athens Access and Up To Date CME Instructions
CME Credit Instructions
CME Follow-Up Survey
Contact Information
CNSRW Ship locator
Fleet Liaison Contact Info: Daytime Office Phone #: 619-532-6430, Fax # 619-532-6404, Duty Phone #: 619-302-8944, email: fmlo-list@med.navy.mil
Phone Directory: Media:INTRANET_PHONE_DIRECTORY_(pao_approved).pdf
Consult Guidance
Consult Appointment Management Office (CAMO) Powerpoint
CAMO CT Surgery Matrix
CAMO Endocrinology Matrix - December 2013
CAMO General Surgery Matrix (revised - February 2015)
CAMO GYN Matrix - February 2014

CME – how to


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To evaluate the program and display your certificate, please follow the steps below:
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I already have a password, and my password is:
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I am a new user (You'll create a password later)
3. Enter CME Activity Code 7755
4.
Sign In
(be sure your browser allows pop-ups)
If you would like to view or print a past certificate, please click here
*Note-Reprint of certificates valid only for certificates received after 10-1-11

CME Information

- CME Code (To claim credit online): **8450**
- Closing Date (To claim credit online): **01 JUN 2016**
- To complete CME
  - Log onto the MRD IDC website and click on the CME credit link

    or
  - Go to NMCSD SEAT SharePoint site (via citrix or NMCSD/BMC computer) and click on MRDSD Waterfront Meeting

http://nmcsd-as-spfe05/sites/dpe/setd/Lists/cmesurvey/Item/newifs.aspx?List=be0f840e%2D0489%2D4b5a%2Db8de%2D9c4cd1a323e5&Web=0901130e%2Dd444%2D45b8%2D8bc7%2D5b9ec10dca77